



**PLUMBERS & PIPEFITTERS LOCAL UNION 344
HEALTH & WELFARE FUND
4337 S W 44 Street
Oklahoma City, OK 73119-2857
405-682-4581**

PREVENT DELAYS - ANSWER ALL QUESTIONS

This form must be completed and signed by the member before any claims will be processed. All questions must be answered. Remember if you are adding dependents, include copies of Birth Certificates and Social Security Cards

SECTION ONE - MEMBER INFORMATION			Please check if this is a change of address
Name		Mailing Address	City, State, Zip Code
Date of Birth	Social Security Number	Home Phone	Local Union # 344
Are you covered under any other Dental, Vision, or Group Health Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No • Check all that apply <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Medical <input type="checkbox"/> Prescription If Yes, You must complete section 3 (Insurance Information)			Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No
SECTION TWO - SPOUSE INFORMATION			
Spouse Name		Date of Birth	Social Security Number
Spouse Address			
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Name & Address of Employer	Is spouse covered under any other Dental, Vision or Health Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No * Check all that apply <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Medical <input type="checkbox"/> Prescription If Yes, You must complete section 3 (Insurance Information)	
SECTION THREE - OTHER INSURANCE INFORMATION			
Name of Insured		Insured's ID Number	
Policy or Plan No.		Type of Coverage <input type="checkbox"/> Individual <input type="checkbox"/> Family	
Name, Address and Phone No. of Insurance Co.			
List all family members who are covered on this plan.			

I certify that all information is true and correct. I authorize the release of any and all medical records to the administrative management for the purpose of determining my benefits payable under the provisions of this plan and any other plan.	
DATE	MEMBER'S SIGNATURE

PLEASE LIST ADDITIONAL DEPENDENTS ON BACK

Dependent Name		Date of Birth	Social Security No
Dependent's Address			
Relation to Member <input type="checkbox"/> Child <input type="checkbox"/> Step Child	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Is dependent covered under any other Dental, Vision, or Health Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No * Check all that apply <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Medical <input type="checkbox"/> Prescription	
Child living with you? <input type="checkbox"/> Yes <input type="checkbox"/> No Child under the age of 26? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, You must complete the following: Name of Insured _____ Group or Plan Number _____ Insured's ID No _____ Type of coverage <input type="checkbox"/> Family <input type="checkbox"/> Individual Name, address & phone number of Insurance Co.	
Dependent Name		Date of Birth	Social Security No
Dependent's Address			
Relation to Member <input type="checkbox"/> Child <input type="checkbox"/> Step Child	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Is dependent covered under any other Dental, Vision, or Health Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No * Check all that apply <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Medical <input type="checkbox"/> Prescription	
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